MONTANA
Department of Public Health & Human Services

January 2006

Medicaid Frequently Asked Questions and Answers

ELIGIBILITY

Q. Where can applicants receive an application for Medicaid?
A. From any Local Office of Public Assistance.

Q. If a client is entering a nursing home, what kind of asset resource transfer can they do to qualify for Medicaid? Can they gift a home to a child or must they sell it?
A. If the client does not sell the home for Fair Market Value, an asset transfer penalty (ineligibility period) will be assigned to the person that runs from the date of transfer forward.

Q. Do infants automatically get coverage too?
A. If the mother is eligible for and receiving Medicaid at the time of birth, then the baby is enrolled in the Automatic Newborn program. This provides coverage for up to one year for the infant, as long as the baby is living with the mother in Montana, and the household countable resources are under $3,000.

Q. Can a provider sign the Medicaid application if the applicant is not capable?
A. Yes, if the applicant is not able to complete the application, another party, including a provider may assist. However, the provider cannot apply on a patient's behalf if the patient is not willing to apply for Medicaid.

Q. How does eligibility information come from the Local County Office of Public Assistance to ACS? How long does this take?
A. OPA workers enter client information into TEAMS. This gets uploaded and passed to ACS every night. Nursing Home spans take longer because of the additional check to verify the initial span. If you are having specific questions or problem clients, call Kathe Quittenton to resolve. Another option is to call the PR staff to help facilitate this.

Q. Can you tell me a little bit about incurment amounts and how providers get caught up in this?
A. Incurment is for patients who don't meet financial eligibility until they spend down their income on medical services. On a certain day they are eligible for everything except a specific provider with whom they meet their incurment. Ideally, the client should receive a copy of their incurment at the OPA and should give it to you.

Q. How far back can medical bills go and still be counted for incurment?

A. Paid bills can be counted for three months prior to the current month. Unpaid bills can be counted as long as the patient is still financially responsible for them (that is, as long as the provider has not written the bill off).

Q. What is the difference between QMB, QMB only, and Medicare/Medicaid?

A. QMB only clients receive a Medicaid hard card. Under this program, Medicaid pays the client's Medicare Part A and Part B premiums, Medicaid's portion of the Medicare coinsurance and deductibles up to the qualified amount. Clients are only covered for Medicare allowed services.
QMB Medicaid- Clients are eligible for Medicare, Medicaid, and QMB. A client who has QMB and Medicaid receives a Medicaid card. Under this program, Medicaid pays the client's Medicare part A and B premiums, Medicaid's portion of the Medicare coinsurance and deductibles up to the qualified amount. Clients are covered for Medicare allowed services, as well as services that only Medicaid allows. If however, Medicare denies a service for medical necessity, Medicaid will also deny for the same reason. Clients are responsible to make Medicaid cost-shares for services only paid for by Medicaid.
Medicare/Medicaid – For clients that are dually eligible, Medicaid only pays for services allowed by Medicare. The client is responsible for their Medicare premiums.

Q. What does SLIMB stand for?

A. Special Low-Income Medicare Beneficiary – in this program Medicaid pays for the premium for Medicare but no services.

MEPS/FAXBACK/AVRS

Q. If you call a claim up in MEPS, and it has denied for invalid diagnosis code, is it possible to go further to find out why?

A. No, since the site is secure and contains no medical information, you must review your remittance advice and call Provider Relations.

Q. What if we look in MEPS and it shows the client is eligible, but ACS denies the claim for client not eligible or not found?

A. If that happens, contact PR and they will ask you to fax the MEPS information and we will fix the eligibility. We do not determine eligibility – it is determined on a local level, it goes to the eligibility broker, and then it comes over to us. We will get the claim processed for you if this happens.

Q. If we have new providers, how do I get them added to MEPS?

A. Complete the access request form using your existing group number requesting that the new numbers be added.

Q. When you use MEPS and the only information you can receive is your own, how do you find out how many units have been used for a service that has limits, such as prior authorized limits, or limits for mental health service plan?
A. Call Provider Relations at ACS, they can look up prior authorization limits.

PASSPORT

Q. Where on the CMS-1500 form do you put the PASSPORT provider approval number?
A. You need to put the PASSPORT provider number in box 17A (ID number of the referring physician). You don't have to have the name of the provider, only the provider's number.

Q. What services do not need PASSPORT approval?
A. If you are a PASSPORT provider, you should have a PASSPORT Provider Handbook which covers PASSPORT approval. The manual *Medicaid General Information for Providers II*, *Appendix A* lists the services that require approval from the PASSPORT provider.

Q. Every time you call for PASSPORT approval do you have to speak to the doctor?
A. No, the office staff can relay the information, but the doctor has to actually give the approval.

Q. Is it the client's responsibility to get approval before they visit another provider?
A. If you want to make sure that you get paid, it is the provider's responsibility.

Q. Are PASSPORT providers assigned without the client's knowledge? We have trouble getting approval from the primary care provider.
A. We are required to assign a PASSPORT provider to a client if the client does not select a PASSPORT provider for themselves. The client is notified that they have been assigned a provider. It is the provider's responsibility to manage the patient's care. You can ask the patient to choose you as the PASSPORT provider if the patient is new to you. Providers and patients can disenroll. Certain circumstances will allow a patient to be exempt from managed care.

Q. What if a provider calls for PASSPORT three months ago and our PASSPORT number changed, which number do we give?
A. If you had made the referral originally then you would give the PASSPORT number that was effective on the date of service, if you did not give the original referral you do not have to give your approval after the fact, just to allow that provider to receive payment.

Q. We have a patient that we referred to a specialist and that specialist referred to another specialist but we have no record.

A. This is piggy backing and shouldn't happen, but if it does, if you feel you are still managing the patient's care you can give the approval for the second specialist. No referral has to be written, but must be noted in the record.

Q. If the PASSPORT provider sends a referral does that qualify or does the provider still need to call?

A. If the PASSPORT number is on the referral that is all you need.

Q. Are all clients PASSPORT except for those in nursing home?

A. Most clients are required to be on PASSPORT. Clients who are not eligible to participate in PASSPORT are those clients living in a nursing home or other institution, clients receiving Medicare and Medicaid, clients classified as medically needy and have an incurment, clients receiving Medicaid for less than three months, subsidized adoption, eligibility is only retroactive, and client receiving Home and Community Based Waiver Program Services. Some clients may also apply for a medical hardship. For example, clients in a residential treatment arrangement, like those kids in the School for Deaf and Blind. Exemptions can be requested for other situations as needed.

Q. Can you use the hospital's PASSPORT approval for the physician on call?

A. It is up to the PASSPORT provider to outline what the referral is for when he/she is called for the PASSPORT facility approval. It cannot be assumed that a hospital facility approval is an approval for any and all services.

Q. Is there a mechanism to change the PASSPORT provider when a patient moves?

A. Since there is not a requirement for patients to change their PASSPORT provider it is not mandatory for them to do so. However, if MAXIMUS notices that there is an address change, the client will receive a request to choose another provider.

Q. On PASSPORT, is the PASSPORT approval the same thing as the provider's Medicaid ID number?

A. No. As of February 1, 2003, the PASSPORT number is not the provider's Medicaid number.

Q. Why are clients allowed to change PASSPORT providers so often?

A. This is determined by the state – some states have a lock-in period. Our state allows clients to change PASSPORT providers every month if they desire. Less than 4 % of Medicaid clients change providers each month. Less than 2% change providers more than 3 times a year.

Q. Who is responsible for getting the PASSPORT approval – the provider or the client?

What do we do when clients come with no referral?

A. It is ultimately the provider's responsibility to contact the PASSPORT provider for approval for the client to be seen in the other provider's office. When you ask the client what insurance they have, if they say Medicaid tell them you cannot meet with them until you get PASSPORT approval.

PASSPORT Approval Denied

Q. If PASSPORT approval was denied by provider for having not seen the patient previously, what can you do?

A. Refuse to treat the client or encourage the client to see their PCP, explaining why that is important. The PASSPORT provider has the right to deny their approval of any service.

Q. We have a walk-in clinic and since they sometimes come in on the weekend, obtaining PASSPORT is difficult. We advise them that if they cannot get PASSPORT approval that they can either be responsible for the charges or wait and see their PASSPORT provider.

A. You either need to accept them as Medicaid, including PASSPORT, or take them as private pay at that time. It cannot be a "you may be responsible" situation – it either has to be, you accept them as private pay right away and take their money, and then try to get approval, and then refund the money. Or accept them as Medicaid and just try and get approval.

Q. Is there some way that if a PASSPORT provider will not authorize a service, can the patient go to Medicaid and get that?

A. If the PASSPORT provider does not authorize the service, they can ask to have their PASSPORT provider changed, but we do not override the PASSPORT provider's decision.

Q. You mentioned before about working the enrollee list – can they drop a patient or is the patient the only one who can change?

A. Give 30 days notice – send letter to client and to PASSPORT. Currently there are four reasons providers can disenroll client, and that is in the contract.

TPL/MEDICARE

Q. Do you have to send a claim to the other payer if the provider knows the insurance is going to deny?

A. Yes, we may not know that the claim will be denied. You can get a blanket denial to attach to your claims that we will accept for two years.

Q. What about when a client has Medicare/Medicaid coverage, and the service is denied by

Medicare for not being medically necessary?

A. Medicaid follows Medicare's determination of medically necessary.

Q. What about those cases where Medicaid shows a TPL, but the provider can't get any information from either the client or the other carrier?

A. Turn over to the TPL unit. They will contact the insurance company to verify coverage and update our records as appropriate.

Q. If you give us a denial, and we have to resubmit a particular line and it's Medicare/Medicaid, when we resubmit that line, do we need to resubmit the Medicare EOB?

A. The answer is yes, we need the Medicare EOB every time.

Q. What happens if the message says it crossed over, but the client ID wasn't correct? If we send it on paper to get paid, will it, or will it be denied?

A. You must wait 45 days after the Medicare payment date to submit the claim to ACS on paper or the claim will be returned to you. If the client ID # was incorrect, you should send the paper claim with corrected client ID to ACS after waiting the 45 day period.

Q. What if the TPL doesn't pay, what documentation do we need to submit to Medicaid?

A. If the TPL hasn't paid within 90 days, you can submit documentation of when you filed the claim with the private insurance company with the TPL unit at ACS. ACS will then pay the claim, and then chase the TPL for you.

Q. When a patient is currently on Workers Compensation, and they come to you for a complaint unrelated to the Workers Comp. Is a denial required and do we need to submit that bill in hard copy?

A. A denial is not required, but you do need to submit the bill in hard copy to the Medicaid TPL unit with "not related to Workers Compensations" on the claim.

Q. There are some patients that have cancer policies, but the patient is not being seen for cancer related illness.

A. Get a blanket denial from our TPL unit, call 406-443-1365.

Q. Can you get an override form for services not customarily covered by an insurance company, so that you don't have to send the claim to the TPL first and have it denied before Medicaid can pay?

A. Yes. It's called a blanket denial letter, and when you send your Medicaid claim in, the TPL unit will verify that the blanket denial letter is accurate for that service before overriding the TPL insurance.

Q. If I have an EOB from private insurance listing a paid amount, do I need to attach the

EOB to the claim?

A. No. You only need to record the actual payment from the TPL. If the claim was denied by the TPL, then you would need to attach a TPL EOB along with the explanation or reason code for why it denied, or if the allowed amount went towards the person's deductible.

Q. Is it true that UB providers (including Rural Health Centers, Federally Qualified Health Centers and Home Health) do not have to include a Medicare EOB?

A. Yes. The Medicare payment needs to be in Field 54 with the coinsurance and deductibles in Fields 39-41 with the appropriate value code.

Q. What happens when the insurance company sends the payment for a claim to the patient rather than the provider? Can we bill the patient the entire amount?

A. No. You can only bill the patient for the amount listed on the insurance company's EOB.

Q. What fields on the UB-92 should be used to indicate Medicare coinsurance and deductible if the Form Locator 39 is used by the provider for something else?

A. The provider may also use Form Locator 40-41 to report that information.

Q. We are not a Medicare provider, but we have a client that we send in to Medicaid and it denied from Medicaid because there was no Medicare EOB.

A. If you are not a Medicare provider, we cannot process that without a letter stating that you are not a Medicare provider.

Q. If you are not on the crossover file, whom do you call?

A. Provider relations at 1-800-624-3958 or send them a note with the information of which Medicare numbers you want to cross over to which Medicaid provider numbers.

Q. With Medicare when you adjust a claim you can't just adjust a line, you have to adjust the whole claim, then the deductible amount changes and you have to adjust Medicaid adjustment form. Is there a simple way?

A. No, but what you can do is send us an adjustment that indicates that Medicare information has changed on the face of adjustment and we will review the coinsurance and deductible. Adjustments do not come to us electronically from Medicare. Also you need to attach a new EOMB.

Q. What is considered proof of billing the private insurance for pay and chase to begin?

A. If you send a letter indicating the date you billed, which insurance company and sign it, we will accept that as proof of billing.

CLAIMS PROCESSING

Q. When we file claims electronically, how long do we keep EOBs?
A. 6 years and 3 months

Q. Do you ever send the actual claim back?
A. Yes, if one of the basics is missing (provider number, bill date, signature) we will return the entire claim to the provider with a letter stating what problems were found.

Q. Do you only process clinic claims one week, and then hospital claims the next week?
A. No. We are constantly processing all the claims that come into the office, regardless of claim type.

Q. How long does it take to get payment?
A. It can take anywhere from two to six weeks, depending on the backlog of your claim type and whether your claim is keyed or sent in electronically. If sign up for weekly payment, you must also sign up for Electronic Funds Transfer (EFT) and Electronic Remittance Advice.

Q. Do you not pay for claims under five dollars?
A. If only one claim is submitted for payment, and the payment is under $5, then we will wait until the next time a claim is submitted and add those claims together for a payment over $5. However, two times a year, we reduce the payment threshold to one cent to release all small checks.

Q. Is FA-455 sent to PR or Claims?
A. The FA-455 form must be attached to each claim and sent to PO Box 8000 for regular processing.

Q. Do all diagnosis codes get keyed?
A. Yes, up to four diagnosis codes per claim on a CMS-1500 and nine on a UB-92.

Q. What if there is a child who comes in for immunizations, and there are more immunizations than spaces for diagnosis?
A. You can make the diagnosis pointer point to whichever diagnosis you'd like for child immunizations- the diagnosis doesn't have to match the procedure in this case only. ACS can still only enter four diagnosis codes for the claim.

Q. What do we do if ACS says a claim was paid, but I am unable to find it on the remittance advice statement?
A. If you call Provider Relations they can give you the date of the statement. If you are still unable to find it, someone in PR can pull your statement for that time and send it to you.

There is a dollar per page charge for this service.

Q. If a provider has done a sterilization, and the client gets retroactive eligibility, can the provider bill Medicaid without the sterilization form?

A. No. You cannot bill Medicaid without the correct form. If the provider suspects that the client may become eligible for Medicaid, the provider should have the client sign the form prior to the sterilization. However, for a medically necessary sterilization, you can send the claim and supporting documentation, including operative notes and the physician's statement to the Department for review.

Q. A client became retroactively eligible during their hospital stay. They were in the hospital on 5/30/01, but they were eligible for Medicaid on 6/01/01. Medicare requires dates of service from 5/30/01. How can the provider bill this?

A. They will have to prorate the stay for Medicaid eligibility both on the Medicare EOB and on the Medicaid claim.

Q. What is the receipt date for electronic claims, is the date received the same as the date sent?

A. The receipt date is the date the claim is actually uploaded onto the mainframe. This ordinarily is the day after it is received, except for weekends and holidays.

Q. How do you submit a claim for a recently born child without an ID?

A. You cannot submit the claim until you get some sort of ID number from the county – either their original ID number from the county or their SSN. Our system cannot pay a claim without an ID. Clients or providers can call the client's local Office of Public Assistance. The OPA will assign an original ID number to the baby so claims may be paid.

Q. When you get denials while the provider is in the process of changing their provider number, is the provider responsible for adjusting claims?

A. These claims are not paid, so the provider is responsible for resubmitting the claim with the proper Medicaid provider number to ACS.

Prior Authorization

Q. Can you bill for fewer units than are authorized?

A. Yes, less is fine, more is not.

Q. What about a Prior Authorization that has multiple lines, since a CMS-1500 claim can only have six lines?

A. As long as the separate claims have the appropriate Prior Authorization number and match the information on the Prior Authorization on it they will process.

Adjustments

Q. If I have an error can I submit a corrected claim at the same time that I send the claim credit?
A. Yes. However, please make it clear that you would like the corrected claim submitted after the claim credit is processed.

Q. When adjusting a claim, do you need a copy of the original bill?
A. No, you don't have to send a copy of the claim. If you want, please send a copy of the corrected claim. There is an exception for UB billers – if you are combining an inpatient and outpatient claim, please send an updated, corrected claim.

Q. What happens if you get paid for clients that aren't yours?
A. If this happens, please call Provider Relations and we will take care of this by doing a claim credit.

Q. What about if you are sending an adjustment to add a TPL payment, do you need to send the EOB?
A. No – just put the information in the correct box in part B of the adjustment form.

MEDICAID POLICY

Billing Medicaid Clients

Q. Can we bill the client for a code that you do not pay on?
A. If it is a non-covered service, and the client is told prior to the services being rendered you can bill the client.

Q. If you have one service that is non-covered at the same time as other services provided that are covered, does the fact that I establish private pay for the non-covered service mean that I could not bill Medicaid for the other services?
A. No, it does not mean that you cannot bill Medicaid for the other services.

Q. If a patient is not eligible, but we do not know they aren't eligible until after the treatment because they do not provide a card, we cannot charge them?
A. You can tell a patient who does not present a card that you are not willing to accept Medicaid for them until you have seen their Medicaid card and verify their eligibility. You will take them as a private pay patient until that time. If you do not see the card and choose not to verify eligibility through another method, you will be responsible for that patient's charges.

Q. What can an Emergency Department do with a client who continues to present to the ED with non-emergent symptoms? If we determine they have Medicaid can we arrange for private payment?

A. EMTALA prohibits a delay in providing the required screening or stabilization treatment in order to inquire about payment methods or insurance status. You are okay to ask what insurance the client has and to ask to get the card to make a copy of it **as long as in doing so, you do not delay giving the screening/stabilization.** You might have a script, which you follow, stating to clients that seeing them for the medical screening examination and stabilization treatment (if an emergency does indeed exist) does not in any way imply that you have accepted their method of payment (whether it be private insurance, Medicaid or Medicare). Payment will be discussed **after** completion of the medical screening examination and at that time it **could be** decided that you will be required to pay privately.
EMTALA prohibits making the "private pay arrangement" **prior** to initiating the medical screening examination. As soon as it is initiated, payment conversations can take place.

Q. On our form for the patient to sign, determining their insurance, can we add a line that states the patient will be responsible if Medicaid won't cover the service or if the client is not eligible?

A. For a non-covered service, you cannot have a blanket form—it has to be specific as to the service that is not covered and what the patient will be expected to pay. You could create a blanket form stating that if the client is not eligible for Medicaid that they will be responsible for the bill. This is the case even if you do not have a form signed by the client.

Q. Can we bill for no shows for Medicaid clients.

A. You cannot bill Medicaid or the Medicaid client for no show.

Q. If we have it posted in our office that after three no shows we will not accept you any more, is that ok?

A. Yes, as long as you treat private pay and Medicaid patients the same.

Q. We bill someone as private pay and then when they go to collections they tell us they have Medicaid, what can we do?

A. If you had established private pay with that client, then you can continue that process and turn them over to collection.

Cost-Sharing

Q. Is a pregnant woman still exempt from paying cost sharing if the services are not related to her pregnancy?

A. Yes. Pregnant women are exempt from paying any cost sharing. Montana considers pregnancy lasting through the postpartum period. The postpartum period begins on the last day of pregnancy and extends 60 days and then goes to the end of that month.

Q. Is there a rule that you can refuse service if a client won't pay their cost-share?
A. You cannot refuse service outright to Medicaid clients who will not pay their cost-share. However, if your office policy is not to serve people who have an outstanding balance, and all clients are notified of this at the beginning of their treatment, you can follow your office policy with Medicaid clients as well. You cannot treat Medicaid clients any differently than you treat clients with private insurance, Medicare, or private pay clients.

Q. Can you have a policy that states that cost-share must be paid in advance?
A. No, you cannot. The goal is not to deny service to patients just because they cannot pay their cost-share at that time.

Q. When you say no balance billing, are we required to receive that cost-sharing from the patient, or can we write it off if they are unable to pay? Is that part of their spend down?
A. No, you do not have to collect cost-sharing from a client – you may choose to write off that amount if you'd like. Cost-share is included in spend down provided the Medicaid client actually paid it. The provider can give the client a receipt which is needed to verify payment.

Other/Miscellaneous Policy

Q. If a provider has a problem with a particular client not showing up for appointments, does the office have to give a reason for refusing to see the patient anymore?
A. No, the provider can tell the client over the phone that the provider is severing the relationship. The provider should also follow-up in writing to keep as written documentation in the client's file. Make sure not to treat Medicaid clients differently than private pay, and often you need to treat them better.

Q. Do you consider urgent care facilities the same as an Emergency Room?
A. No, they are not considered emergency.

Q. If we have a visitor from another state, do we have to enroll as a provider for another state?
A. No, enrolling as a Medicaid provider is voluntary enrollment, so you can make the choice whether to enroll with that state's Medicaid program or arrange for the client to be private pay.

Q. What do you consider a new patient, a patient leaves for three to four years then comes back, are they new or established?

A. There is a three-year guideline – after three years the patient is considered new.

MEDICAID SERVICES

Q. I work in a public health clinic, and I get claims back saying that the client has MHSP, and you are not a mental health provider and can't give them shots.

A. Because MHSP is 100% state funded, these clients can only get mental health related services. They are not Medicaid clients, they are MHSP clients.

Q. What happens when a patient is ordered to get a walker? The client wants the fancy walker, but Medicaid will only pay for standard walker. Both walkers have the same procedure code. Could we bill the patient for the difference between the fancy walker that is not covered and the standard walker that is?

A. If they want the fancy walker, and only require the standard walker then the fancy walker is considered a non-covered service. The patient should pay for the full amount of the non-covered service. Put it in writing that this is a non-covered service.

FRAUD AND ABUSE

Q. Who do I call to report provider or client fraud or abuse?

A. The following hotlines and phone numbers are available to you in matters regarding suspected fraud and abuse:
Provider Fraud or Abuse: 1-800-376-1115 (MFCU: Medicaid Fraud Control Unit); or,
(406) 444-4586 (SURS: Surveillance and Utilization Review)
Client Eligibility Fraud: 1-800-201-6308
Client Abuse: 1-800-362-8312 (Team Care)

OTHER/MISCELLANEOUS

Q. If SURS comes back and takes the money, can we bill the Medicaid client?

A. If the provider made an error that resulted in overpayment or Medicaid made an error in processing, no you cannot bill the patient.

Q. Is the ARM on the DPHHS web site?

A. They are on the section of the web site: http://www.dphhs.state.mt.us. Select legal services, then Administrative Rules of Montana. Most of the Medicaid rules are in section 37.

Q. What is the Provider Information Web site address?
A. http://www.mtmedicaid.org

Q. Where can you find the Montana Code?
A. On the Internet – go to www.discoveringmontana.com, Government, Montana Constitution and Laws, link to MT Codes.

Q. How do I get a new fee schedule?
A. Provider Information web site at www.mtmedicaid.org